PRINTED: 07/20/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G062	B. WING		07/	01/2022	
	OS PLACE EAST			STREET ADDRESS, CITY, STATE, ZIP CODE  1829 ROKEBY AVENUE  CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 000	Initial Comments		E 00	00			
	survey was conduct 07/01/22. No correct compliance with the requirements and was Long Term requirement will follow.  The census in this survey was 5. The	Standard Medicaid/Medicare ted on 06/28/22 through stions are required for Emergency Preparedness with 42 CFR Part 483 Federal ments. The Life Safety Code  5 bed facility at the time of the survey sample consisted of 3 (Individual #1 through #3).					
W 000	INITIAL COMMEN	rs	W 0	00		201	
	survey was conduct 07/01/22. Correction with 42 CFR Part 4	Standard Medicaid/Medicare ted on 06/28/22 through are required for compliance 83 Intermediate Care Facilities Disabilities (ICF/ID) Federal					
W 154	survey was 5. The current Individuals		W 1	54			
	violations are thorough This STANDARD Based on observation interview, the facilities investigate a fall in	ave evidence that all alleged bughly investigated. is not met as evidenced by: tions, record review and staff ty staff failed to thoroughly involving one Individual he survey sample of 3		CIBH will continue to conthorough investigation as W154, Human Rights Reand internal policy by: the of interviews, statements evidence, and any pertine pictures or diagrams, revinformation related to the resolution of any discreps summary of conclusions, recommendations for act	indicated by gulations, e collection, physical ent maps, iew of all allegation, ancies, and		
	A DIDECTOR'S OF BECAUSE	ED/SLIPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Clinical Supervisor

07/29/2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		49G062	B. WING	<u> </u>	07/	01/2022	
	ROVIDER OR SUPPLIER		18	TREET ADDRESS, CITY, STATE, ZIP CODE 829 ROKEBY AVENUE HESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 154	with diagnoses which Intellectual Disability osteoporosis, bilate moderate visual impulsation of the moderate o	dmitted to the facility on 4/9/14 ch included Profound y, spastic diplegia, ral hearing impairment, pairment, edema, bilateral ure disorder. Resident #3 had cliner on 02/06/22 which d displaced fracture of	W 154	Highlands Place staff will commonitor the services and car residents, and report allegatineglect, exploitation, and other areas of care per agency polynomials.  AOC:7/27/2022	e of all ions of abuse ner		
	of pain after the inc in her wheelchair a began providing su a large bruise on Ir neck area. Nursing	ndividual #3 showed no signs sident and was moving around as normal. When morning staff apport to Individual they noticed individual #3's shoulder and a staff were contacted, and sported for medical evaluation					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		49G062	B. WING _		07/01/2022		
	ROVIDER OR SUPPLIER  DS PLACE EAST						
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
W 154	a closed displaced clavicle. Due to the APS (Adult Protecti well.  Injuries: Individual Injured? Type of Injury: Brui Medical Attention P Description of Med Finding: Individual #3 was of started on the morrand neck area. State hospital for assess scans and X-rays of the APS (Adult) and the started on the morrand neck area.	vidual #3 was diagnosed with fracture of acromial end of left nature of the incident/injury ve Service) was contacted as  Yes es - Fractures	W 1	54			
	Tylenol and Naprox required."  An Internal Report Quality Assurance An incident report Quality Improveme completed by DST Individual #3 was replanded with her legited that DST and was document stated she administ medication and who "covered her head walked into the kitt when she heard a Individual #3 had "sitting" on the floor	dated 2/15/22 prepared by the Analyst indicated: Allegation: "was received by Continuous ent (CQI) on Sunday, 2/6/22 #1. DST #1 reported that relaxing in the recliner with her gs elevated for pain. DST #1 #2 was present in the room ting his temperature. DST #1 stered Individual #3's leen complete Individual "with her blanket DST #1 chen to discard the medicine "bump". DST #1 noted that stid" out of the recliner was for. DST #3 documented and there was no medical					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OS PLACE EAST		STREET ADDRESS, CITY, STATE, ZIP CODE  1829 ROKEBY AVENUE  CHESAPEAKE, VA 23320				
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W 154	Continued From pag	e 3	W 15	54			
	Staff Interviews:						
	DST #2 2/8/22						
		ed into the building on 2/6/22,					
		ual #3 on the sofa recliner					
		e reclined position. DST #2 ndividual #3 is in the recliner	1000	B 8 1 1			
	reported that when i	, she is supposed to be in the					
	reclined position.	, and is supposed to be in the					
		ed to the (sic) writer how DST					
	#2 and DST #1 obse	erved Individual #3 after they					
	heard the "bump". D	ST #2 laid on the floor in					
	front of the sofa recl	iner on his left side. The	- 1775/16				
	recliner was remained	ed in the upright position."					
	100 March 20						
	Staff Interview:			× .			
	DST #1 2/9/22	dividual #3 was "sleeping" in			a c		
	the recliner on 2/6/2	2 with her feet up and her					
		ad. DST #1 reported that she					
		o give her medication and					
	then turned and wal	ked to the kitchen to discard					
		ndividual #3 placed the		=			
	blanket back over h	er head before DST #1 left					
		#1 reported that DST #2 had	1 99	0			
	entered the building	and was logging his					
	temperature at the	entertainment center, with his					
		3. DST #1 stated she put her		9			
	foot on the trash ca	n step to open the lid and eportedly, DST #1 and DST #2					
	neard a "thump . Re	d Individual #3 on the floor in		SEE OF V			
		with the footrest still inclined."					
	DOT #4 (1-1-1 #-1	Individual #3 was lying on hor					
	UST#1 stated that	Individual #3 was lying on her DST #1 was pointing to her					
	Inght side, although	(sic) brought this to DST #1					
	attention but DST	#1 again stated it was the right					
	side."	,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING _	CONSTRUCTION	COMPLETED		
		49G062	B. WING		07/01/2022	
	OS PLACE EAST		1	TREET ADDRESS, CITY, STATE, ZIP CODE 829 ROKEBY AVENUE HESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
W 154	protocol that indicate experienced a fall, so Individual #3 for furth Program Supervisor protocol in place at Individual #3 must be evaluation.  Program Supervisor supervisor supervisory staff are and making revision involving falls. Addit reviewing options an orders for modifying for Individual #3."  Documentation Rev Individual #3's servi with a start date of the following:  "Start date: 05/10/2 Target date: 05/09/3 Goal/Desired Outcot Fall risk Individual #3 minim Objective (active tre help with): Individual #3 is sup of falls due to unstee equipment. (pivot be safety straps, show recliner, bed alarms person support with	r was asked if there was a ed if Individual #3 staff are required to take her medical evaluation. Treported no there is not a this time that indicates he taken for further medical reported that she and reviewing current protocols as as needed for incidents ionally, Program Supervisor is and obtaining the necessary the sofa recliner with a strap riew:  The ce plan completed 11/30/21 strain for the sofa recliner with a strap riew:  The ce plan completed 11/30/21 strain for the sofa recliner with a strap riew:  The ce plan completed 11/30/21 strain for the sofa recliner with a strap riew:  The ce plan completed 11/30/21 strain for the sofa recliner with a strap riew:  The ce plan completed 11/30/21 strain for the sofa recliner with a strap riew:  The completed strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the sofa recliner with a strap riew:  The complete strain for the	W 154			
	provided based on	s (Describe how this will be individual preferences).: at areas are free and clear of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COMPLETED		
		49G062	B. WING		07/01/2022		
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
W 154	clutter to reduce ris Staff will support by properly secured w shower chair are b Staff will insure prostanding to help re Staff will insure floor alarms are on and Staff will utilize pive transferring Individ Staff will monitor Infor safety to ensure staff's support. For How often or b Responsible Partn The writer (sic) spon 2/11/22 regardith that indicates a sa when Individual #3 During an interview the Program Super Individual #3 come upright position? Proceeded to explinate the reclined so out of the reclined so out of the recliner position. When as in the upright position? Program Supervis When asked if the documented in an other clinical notes stated, No.	sk of falls.  y ensuring safety straps are when wheelchair, recliner and eing utilized.  per use of gait belt when duce the risk of falls.  or mats are in place and bed working properly while in bed. ot board each time when ual #3 for safety. Individual #3 while in the recliner e she does not get up without  y when? Daily er: DSP  oke with Program Supervisor, ing the ISP goal as noted above fety strap would be utilized	W 154				

		IDENTIFICATION NUMBER:		G	COMPLETED
		49G062	B. WING		07/01/2022
	ROVIDER OR SUPPLIER  DS PLACE EAST			STREET ADDRESS, CITY, STATE, ZIP CODE  1829 ROKEBY AVENUE  CHESAPEAKE, VA 23320	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
W 154	called for the use of a sofa did not have a s Individual #3 had the Individual #3 was ob	ecliner. Individual #3 ISP a safety strap but the recliner afety strap until after fall. served seated in the sofa	W 15	54	
	p.m., two staff supports A review of the daily 2/6/22 indicated: Indiremergency". There documentation of a formula A review of the nursing the support of th	was no mention or all. ng notes for Individual #3 on te the head to toe nursing			
	indicated: Policy- It is to document and rep the health, safety an we serve.  Procedure: Facility s any allegations of Hi suspected crime, mi abuse, including fina injuries of an unknow sources as establish	ure Reporting Requirements is the Policy of Highland East port any incident jeopardizing id welfare of the individuals taff must immediately report ruman Rights violations, a streatment, neglect, or incial exploitation, as well as well so well as well as the source, to the appropriate in the streatment in the stream of the			
W 242	investigated and find working days of repo INDIVIDUAL PROGI CFR(s): 483.440(c)(	lings submitted with in 5 orted incident. RAM PLAN	W 2	42	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G062	B. WING		07/01/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
W 242	those clients who lack skills essential for privipal (including, but not limpersonal hygiene, debathing, dressing, groof basic needs), until that the client is deveacquiring them.  This STANDARD is a Based on observation interview, the facility safety strap to prever recliner involving one the survey sample of the findings included Individual #3 was admitted in the property of the survey sample of the findings included Individual #3 was admitted in the property of the survey sample of the findings included Individual #3 was admitted in the property of the survey sample	k them, training in personal vacy and independence nited to, toilet training, antal hygiene, self-feeding, coming, and communication it has been demonstrated elopmentally incapable of mot met as evidenced by: ons, record review and staff staff failed to implement a nt falls while seated in a sofa a Individual (Individual #3) in a individuals.  d:  mitted to the facility on 4/9/14 included Profound a spastic diplegia, al hearing impairment, airment, edema, bilateral e disorder. Resident #3 had diner on 02/06/22 which displaced fracture of	W 242	Highlands Place East's nursing staff of physician's order on 2/14/2022 for safe be use for patient due to fall risk. PCF in accordance with physician's order in and signed by AR. The order was not specific to the recliner. The order was 6/30/2022 to read use of safety strap vidue to fall risk. The Clinician I reviewed order and updated PCP with use of sa in recliner with AR. The updated plan with staff on 7/1/2022.  Highlands Place RN will review all currequipment physician's order to ensure specific to the adaptive equipment bein Individual. After review of orders if clared order is needed, the RN will obtain clared upon receipt of order the person center be updated and reviewed with AR for other Clinician I.  To minimize the risk of reoccurrence, Twill review EHR to ensure physician's obtained before prior to update of person plan by Clinician III  AOC Date: 8/17/2022	ety strap may P was updated In February 2022  clarified on while in recliner d the clarifying fety strap while was reviewed  rent adaptive order is ng utilized for rification of rifying order. ered plan will consent by  The Clinician III, order has been
	1 5	Fall Risk assessment dated s individual as being at high			
		ne #2: Describe			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
		49G062	B. WING		07	//01/2022				
	ROVIDER OR SUPPLIER  DS PLACE EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTI		OULD BE	(X5) COMPLETION DATE
W 242	Continued From pag	e 8	W 24	2						
	help with): Individual #3 is supported falls due to unsteat equipment. (pivot bosafety straps, showe	orted by staff to reduce risk dy gait using her adaptive ard, gait belt, wheelchair with r chair with safety straps, floor mats, adaptive plate, 2 transfers).								
	provided based on in Staff will ensure that clutter to reduce risk Staff will support by a properly secured who shower chair are bein Staff will insure properstanding to help reduce Staff will insure floor alarms are on and work Staff will utilize pivot transferring Individual Staff will monitor Indifor safety to ensure staff's support.  For How often or by Responsible Partner	ensuring safety straps are en wheelchair, recliner and ing utilized.  er use of gait belt when are the risk of falls.  mats are in place and bed brking properly while in bed. board each time when all #3 for safety.  vidual #3 while in the recliner the does not get up without when? Daily								
	recliner with a safety	served seated in the sofa belt on 06/28/22 at 2:40 rted her into the recliner.								
	the Program Supervi Intellectual Disability the safety strap was	on 06/30/22 at 2:30 p.m. with sor and QIDP (Qualified Professional), they stated, on the Individualized Service of been implemented and recliner.			,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		49G062	B. WING		07/01/2022
	ROVIDER OR SUPPLIER  DS PLACE EAST		18	TREET ADDRESS, CITY, STATE, ZIP CODE 329 ROKEBY AVENUE HESAPEAKE, VA 23320	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
W 242	Continued From page	9	W 242		
W 262	was fitted with a safet Individual #3's fall wh clavicle.	sor stated, the recliner sofa ty strap on 2/7/22 following ich resulted in a fractured	W 262	Highlands Place held a Specially Constitute	d
	monitor individual pro inappropriate behavior in the opinion of the or client protection and rather than the standard protection and rather than the standard proved, and monito to prevent falls while involving one Individual survey sample of 3 in The findings included Individual #3 was administration of the standard proved.	d review, approve, and grams designed to manage or and other programs that, committee, involve risks to rights.  not met as evidenced by: lew and staff interview, the ensure the Specially see (SCC) reviewed, ored the use of a safety strap seated in a sofa recliner real (Individual #3) in the dividuals.		Committee (SCC) meeting on 3/29/2022 whoriginal order for use of safety strap due to twas reviewed. The minutes from SCC mee reflect that use of safety strap while in reclinwas discussed utilizing the original order of safety strap due to fall risk; however, the oriorder did not mention recliner. The order wclarified on 6/30/2022 to specifically state us strap while in recliner. A Specially Constitut Committee (SCC) was held by Clincian III to new clarifying physician order stating safety while in recliner. The SCC approved the paclarifying order for safety strap while in recline the AR signed the informed consent form.  The RN will review all current physician order that may affect individuals behaviors or involent protectionand rights to ensure physiciare specific in detailing usage. A SCC mee be held on any physician orders needing class an ongoing measure to minimize the risk physician orders upon receipt at facility will reviewed by RN for potential need of review After review if necassry, SCC meeting will be	ere the fall risk titing ter was use of ginal as see of ted to review the strap use ckage with ner; and ters of the loce East bolve risk to an orders ting will arification.
	Intellectual Disability, osteoporosis, bilatera moderate visual impa glaucoma and seizure a fall from a sofa recli resulted in a "closed of acromial end of left cl review and approve the while Individual #3 was A Physical Therapy F	I hearing impairment, irment, edema, bilateral e disorder. Resident #3 had ner on 02/06/22 which		AOC Date: 8/17/2022	

		The second of the second of the second	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
			49G062	B. WING _			07/01/2022	
	ROVIDER OR SUPPLIER  DS PLACE EAST	3			STREET ADDRESS, CITY, STATE, ZIP CODE 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST B	OF DEFICIENCIES E PRECEDED BY FULL IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 262	Continued From page risk for falling.  Individual #3's service with a start date of 5/the following: "Start date: 05/10/21 Target date: 05/09/22 Goal/Desired Outcom Fall risk Individual #3 minimize Objective (active treathelp with): Individual #3 is supported falls due to unstead equipment. (pivot boasafety straps, shower recliner, bed alarms fliperson support with the Support instructions (I provided based on incomparison of the staff will ensure that a clutter to reduce risk of Staff will support by exproperly secured when shower chair are being Staff will insure proper standing to help reduce is the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will insure proper standing to help reduce with the staff will be staff with the standard	e plan co 10/21 no e #2: D es her ri ment ite rted by ly gait u rd, gait chair w cor mat ansfers Describe ividual reas aru f falls. asuring n wheel g utilized use of	escribe  sk of falls ems that client can  staff to reduce risk sing her adaptive belt, wheelchair with ith safety straps, s, adaptive plate, 2 ).  e how this will be preferences).: e free and clear of  safety straps are chair, recliner and d. gait belt when	W 2	SOURCE LINESPECTATION			
	Staff will insure floor malarms are on and word Staff will utilize pivot be transferring Individual Staff will monitor Individual Staff will monitor Individual staff's support.  For How often or by we Responsible Partner: Individual #3 was observed.	nats are king property and the property	in place and bed operly while in bed. oh time when afety. while in the recliner not get up without					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		100-10-11-2	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		120	49G062	B. WING _			07/	/01/2022	
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320	ÞΕ			
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W 262	recliner with a safety of p.m., two staff support the Program Supervise Intellectual Disability of the safety strap was of Plan (ISP) but had not secured on the sofare The Program Supervise was fitted with a safety Individual #3's fall whice clavicle.  A SCC Plan dated 03/Review/Authorization Adaptive Equipment/Figait Belty Shower Chair with safety Bed alarms	belt on 0 rted her in 06/30/2 sor and 0 Profession the Industrial to been in ecliner.  sor state by strap of ich result  /29/22 in Form:  Protective fety strap plies loci	into the recliner.  22 at 2:30 p.m. with QIDP (Qualified onal), they stated, dividualized Service implemented and ed, the recliner sofa on 2/7/22 following ted in a fractured indicated:  be Devices:	W 21	62				
	Divided Plate.  The SCC plan was ap was no safety strap (a equipment/protective of sofa recliner included)  The Program Supervision oversight leaving the seplan.  PROGRAM MONITOF CFR(s): 483.440(f)(3)()  The committee should are conducted only with	idaptive device) v in the SC sor states safety str RING & C (ii)	while seated in a CC approved plan.  d, that was an rap off of the SCC  CHANGE  that these programs	W 26	63				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	Y	(X3) DATE SURVEY COMPLETED	
os es		49G062	B. WING		07/01/2022		
NAME OF PROVIDER OR SUPPLIER HIGHLANDS PLACE EAST			1	STREET ADDRESS, CITY, STATE, ZIP CODE  1829 ROKEBY AVENUE  CHESAPEAKE, VA 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 263	consent of the client, minor) or legal guard This STANDARD is Based on record rev facility staff failed to consent of the legal g safety strap to prever recliner involving one the survey sample of The findings included Individual #3 was adr with diagnoses which Intellectual Disability, osteoporosis, bilatera moderate visual impaglaucoma and seizura a fall from a sofa recliresulted in a "closed acromial end of left cl not obtain informed or safety scrap while Incosafety scrap wh	parents (if the client is a lian.  not met as evidenced by: riew and staff interview, the ensure written informed guardian for the use of a not falls while seated in a sofa a Individual (Individual #3) in a 3 individuals prior to use.  d:  mitted to the facility on 4/9/14 included Profound spastic diplegia, al hearing impairment, airment, edema, bilateral e disorder. Resident #3 had iner on 02/06/22 which displaced fracture of lavicle." The facility staff did onsent for the use of a dividual #3 was seated in a all Risk assessment dated is individual as being at high the plan completed 11/30/21 noted under goal #2  see #2: Describe	W 263	The original physician's order stating may be used due to fall risk was atta package of information reviewed and in March of 2022. On 7/1/2022, a SC conducted to review clarifiying order safety straps while in recliner. The inconsent for SCC package was updated of safety strap while in recliner by LF.  The RN will review all current inform forms attached to SCC packages for residing at Highlands Place East to econsent from AR or Legal Guardian obtained. To minimize the potential RN will review the entire SCC packaticular including Informed consent page for ensure no nformation has be omitted Legal Guardian signing of consent.  AOC Date: 8/17/2022	ched to the SCd signed by AR CC meeting was stating use of informed ted to include uPN.  ed consent the 5 individual ensure informed has been of recurring, the ge of informatic accuracy to	s se	

A9G062  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE	07/01/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLANDS PLACE EAST  1829 ROKEBY AVENUE CHESAPEAKE, VA 23320		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 13 Individual #3 is supported by staff to reduce risk of falls due to unsteady gait using her adaptive equipment. (pivot board, gait belt, wheelchair with safety straps, shower chair with safety straps, recliner, bed alarms floor mats, adaptive plate, 2 person support with transfers).  Support instructions (Describe how this will be provided based on individual preferences).: Staff will ensure that areas are free and clear of clutter to reduce risk of falls. Staff will support by ensuring safety straps are properly secured when wheelchair, recliner and shower chair are being utilized. Staff will insure proper use of gait belt when standing to help reduce the risk of falls. Staff will insure floor mats are in place and bed alarms are on and working properly while in bed. Staff will utilize pivot board each time when transferring Individual #3 for safety. Staff will monitor Individual #3 or safety. Staff will monitor Individual #3 while in the recliner for safety to ensure she does not get up without staff's support. For How often or by when? Daily Responsible Partner: DSP Individual #3 was observed seated in the sofa recliner with a safety belt on 06/28/22 at 2:40 p.m., two staff supported her into the recliner.  During an interview on 06/30/22 at 2:30 p.m. with the Program Supervisor and QIDP (Qualified Intellectual Disability Professional), they stated, the safety strap was on the Individualized Service Plan (ISP) but had not been implemented and secured on the sofa recliner.  The Program Supervisor stated, the recliner sofa was fitted with a safety strap on 2/7/22 following		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		49G062	B. WING		07/	01/2022
	ROVIDER OR SUPPLIER  DS PLACE EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ULD BE COMPLETIO	
	Individual #3's fall whiclavicle.  A SCC Plan dated 03. Review/Authorization Adaptive Equipment/F Gait Belt Shower Chair with sat Harmful chemical sup Wheelchair with safety Bed alarms Divided Plate.  The SCC plan was ap was no safety strap (a equipment/protective sofa recliner included The Program Supervisconsent had not been safety strap. Nor did the safety strap while Indivisofa recliner. The safety strap while Indivisofa recliner was left off or review/authorization or PHYSICIAN SERVICE CFR(s): 483.460(a)(3)  The facility must proving general medical care. This STANDARD is not Based on observation interview, the facility strap interview, the facility strap interview, the facility strap while Indivisoration or PHYSICIAN SERVICE CFR(s): 483.460(a)(3)	ch resulted in a fractured  (29/22 indicated: Form: Protective Devices:  (ety strap plies locked in storage y strap  proved on 3/29/22. There daptive device) while seated in a in the SCC approved plan.  (sor stated, informed obtained prior to use of the ne SCC Plan include the vidual #3 was seated in the ety strap while seated in the sty strap while seated in the sty strap while seated in the the SCC consent form.  (S)  (S)  (S)  (S)  (S)  (S)  (S)  (S	W 263	A physician's order was obtained on 2/14/stating safety strap may be used due to far The order was in relation to a fall Individua involving sofa recliner. The order was not to the recliner. A new clarifying physician's was obtained on 7/1/2022 by LPN. The neclarifying order was reviewed at SCC mee 7/1/2022 and the informed consent form of was signed by AR after reviewing of the new as signed by AR after reviewing of the new as safety straps) are specific detailing exact usage of the adaptive equipment. If New clarifying orders will be obtained and before SCC if necessary.  To minimize the potential of physician's or being specific, new orders will be review be receipt at facility to ensure order are detail usage of adaptive equipment.	all risk. al #3 had specific 's order but sting on of SCC ew order.  er 4 East to protection g the needed brought  ders not y RN upon	
. 11						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
*		49G062	B. WING			07/01/2022			
NAME OF PROVIDER OR SUPPLIER HIGHLANDS PLACE EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320		ROKEBY AVENUE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		HOULD BE		(X5) COMPLETION DATE	
W 322	The findings included	mitted to include spastic al hearing airment, e disorde iner on ( displace lavicle." order fo I #3 was fall Risk is individual e plan co 10/21 no ne #2: De es her rist tred by	diplegia, g impairment, edema, bilateral er. Resident #3 had 02/06/22 which d fracture of The facility staff did r the use of a safety seated in a sofa  assessment dated ual as being at high ompleted 11/30/21 oted under goal #2  escribe sk of falls ems that client can staff to reduce risk	W3	322				
	equipment. (pivot boa safety straps, shower recliner, bed alarms fl person support with tr Support instructions ( provided based on ind Staff will ensure that a	chair wi oor mats ansfers) Describe	th safety straps, s, adaptive plate, 2 e how this will be preferences).:						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		49G062	B. WING		07/01/2022		
NAME OF PROVIDER OR SUPPLIER HIGHLANDS PLACE EAST		STREET ADDRESS, CITY, STATE, ZIP COD 1829 ROKEBY AVENUE CHESAPEAKE, VA 23320					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	CORRECTIVE ACTION SHOULD BE COMPLE EFERENCED TO THE APPROPRIATE  DAT		
W 322	clutter to reduce risk of Staff will support by e properly secured whe shower chair are bein Staff will insure properstanding to help reduce Staff will insure floor real range are on and wo Staff will utilize pivot be transferring Individual Staff will monitor Individual Staff will monitor Individual Staff will monitor Individual Staff support. For How often or by we Responsible Partner:  Individual #3 was obstrectioner with a safety p.m., two staff support.  During an interview of the Program Supervise Intellectual Disability Intellectual Disability Intellectual Pisability I	of falls. Insuring safety straps are in wheelchair, recliner and ing utilized. In use of gait belt when ce the risk of falls. In use of gait belt when ce the risk of falls. In ats are in place and bed orking properly while in bed. It is a for safety. It is a for saf	W 322				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
49G062			B. WING			/01/2022		
NAME OF PROVIDER OR SUPPLIER HIGHLANDS PLACE EAST			STREET ADDRESS, CITY, S 1829 ROKEBY AVENUE CHESAPEAKE, VA 23:			STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
W 322	Continued From page Shower Chair with sa Harmful chemical sup Wheelchair with safe Bed alarms Divided Plate.  The SCC plan was a was no safety strap (equipment/protective sofa recliner included The Program Superv	e 17 Ifety strap oplies locked in storage ty strap opproved on 3/29/22. There	W 322					